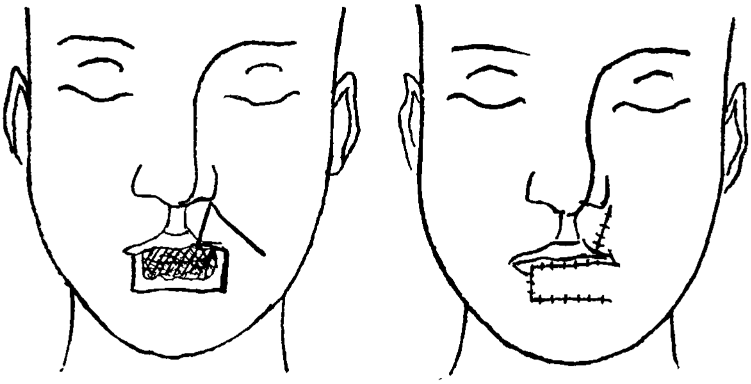
return circulation in the flap, it is possible to cut this flap smaller than the gap to be filled, contrary to the usual need in plastics. The mucous covering of the lower edge of the flap must be dissected off and then the flap is sutured in place. Along the upper border sufficient of its substance is grooved out to allow of the buccal mucous membrane to be sutured to the skin, and thus a mucous covering obtained for the new lower lip. Finally, the incision in the upper lip is sutured vertically to that in the cheek, thus closing the hiatus left by cutting out the flap. Two additional points of suture serve to form the new left commissure.



In the particular case in which this method was employed by the author, the result was very satisfactory. There was no swelling of the flap; the teeth were well covered; the projection of the two lips was uniform. The regularity and symmetry of the mouth left little to be desired. The saliva was absolutely retained by a contractile lip, and in both mastication and phonation the mouth worked normally.—*Bull. et Mém. de la Soc. de Chirurgie de Paris*, 1894, t. xx, p. 643.

II. Congenital Epithelial Cysts and Fistulæ of the Neck. By Dr. O. Hildebrand (Göttingen). The author reports twenty cysts and ten fistulæ of the neck observed at the surgical clinic in Göttingen.

The cysts were not congenital in the sense that they could be seen at birth, but developed gradually and were first observed between the ages of twenty and forty years. They were usually situated in one of the carotid triangles. One only was placed in the median line. Anatomically, these cysts are divided into different groups. The large majority had thick walls and contained opaque mucoid material. The interior resembled mucous membrane in appearance, and had numerous hemispherical elevations on the surface. Microscopically, the walls were found to be composed of flat epithelium resting on a layer of columnar cells. Under this was a layer of loose connective tissue in which were many lymph-follicles. Outside of this was a thick wall of connective tissue. Some of the cysts contained ciliated epithelium and some mucous glands.

Another class of cysts contained hair, sebaceous glands, and other structures characteristic of dermoids.

Of the ten fistulæ all but two were at the side of the neck, and in six of these eight the external opening was between the hyoid bone and the clavicle, and internal to the sterno-mastoid muscle. The interior of the fistulæ showed flat epithelium near the periphery, but deeper they were covered with ciliated epithelium. The inner opening of the fistulæ was usually somewhere in the pharynx. The two fistulæ which occupied the median line terminated internally at the base of the tongue. One contained thyroid tissue in its walls.

The inner openings of these fistulæ indicate from which branchial cleft they originated, and since most of them terminate near the fossa of Rosenmüller, just back of the opening of the Eustachian tubes, it is thought that most of the fistulæ, as well as the cysts, come from the second branchial cleft. The fistulæ are due to a failure of one of the branchial clefts to close and a breaking down of the septum usually closing these structures. When a cyst is present the septum is supposed to remain intact and the inner or outer end of the fistula is closed. In the former case the cyst lies next the mucous membrane, and its internal lining resembles the covering of the pharynx or the tonsil. If the cyst form between the septum and the skin, it must originate entirely from the ectoderm and will be a dermoid. The cysts and fistulæ in the median line are from the ductus thyroideus, the duct from the foramen cæcum in the tongue to the thyroid gland.

III. Congenital Cystic Tumors of the Coccygeal Region. Six tumors have been observed in the coccygeal region, all but one of which were present at birth. They were situated between the rectum in front and the sacrum and coccyx behind. Some were intimately connected with the rectum, but not with the bone. There were three distinct kinds of cysts observed: lymphangiomæ, dermoids, and cysts with epithelium resembling that of the intestine at some period of its development. Cysts of the latter class are most frequently met with. They are usually multilocular, contain opaque mucoid fluid, and are lined with cuboid cylindrical or flat epithelium. Intestinal glands are sometimes present. The walls sometimes contain bone, cartilage, unstriated muscle, or material resembling the spinal cord.

An explanation of the occurrence of these cysts can be found in the fact that the canalus neurentericus occupies this region. The blastopore, the first external opening of the intestine, is situated at the tail-end of the medullary furrow. When this furrow is converted into a canal the opening can no longer be seen from the outside, but opens directly into the medullary canal, so that the intestine and medullary canal form a V-shaped tube. Later the neurenteric canal becomes obliterated. The chorda dorsalis appears between the intestine and medullary canal, and extending backward to form the sacrum and coccyx, completely separates the neurenteric canal from the spinal cord, causing it to lie in front of the coccyx. All the epithelial cysts of this region are due to a persistence of the neurenteric canal. The dermoid cysts are undoubtedly produced from that part of the canal formed by the ectoderm, while the others come from the intestinal end of the canal. Bone and cartilage in the cyst-walls are due to a displacement of some of the chorda dorsalis by the canal, and the presence of material resembling the spinal cord is easy of explanation. The origin of the lymphangiomata is still unknown.—*Archiv für klinische Chirurgie,* Band XLIX, Heft 1.

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